Sherif El-Asyouty, M.D.
PATIENT INFORMATION SHEET

Patient Name: _____ Social Security: _____-_____-_____

DOB: _____/_____/_____ Sex: M F Age: _____

Phone# Home: _____Cell: _____ W: _____

Home Address: _____

City, State and Zip: _____ E-Mail: _____

Employer_____ Phone#: _____

Spouse's Name: _____ Phone #: _____

Employer_____ Phone#: _____

Nearest Relative: _____

Phone #: _____ Address: _____

Primary Care Physician: _____ Phone#: _____

Referral Source: _____ Phone#: _____

Primary Ins. Co.: _____Behavioral Health Phone#: _____

Primary Insured: _____ DOB: _____/_____/_____

SSN: _____-_____-_____ ID#: _____ Group#: _____

Insurance Claim Address: _____

Outpatient Mental Health Co-payment: _____

Assignment of Benefits

CONSENT FOR TREATMENT, RELEASE OF INFORMATION

I hereby assign all medical and/or mental health benefits to include major medical benefits to which I am entitled, including private insurance, and any other plan, to Dr. Sherif El-Asyouty. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release any medical or other information necessary to secure the payment. I hereby authorize Dr. El-Asyouty to perform any medical treatment as deemed necessary. I further agree in the event of non-payment, to bear the cost of collections, and/or Court costs and reasonable legal fees should this be required.

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature (if patient is a minor)

GENERAL CONSENT FOR MEDICAL TREATMENT/HEALTHCARE

CONSENT FOR TREATMENT

I voluntarily consent to care, treatment, testing and all other services performed by Dr. El-Asyouty.

However, I understand that I have the right to refuse to consent to any proposed treatment, procedure or testing, and I have the right to further discuss my concerns with Dr. El-Asyouty.

I understand that the practice of medicine is not and exact science. I acknowledge that no guarantee have been made to me as to the result of examination or treatment.

RELEASE OF MEDICAL INFORMATION

I understand that Dr. El-Asyouty shall maintain a record of the medical care that I receive. This record will typically include information about my symptoms and a plan regarding future care and treatment. This information is considered "Protected Health Information" as, as such, will only be used or disclosed for the purpose of treatment, payment and healthcare operations, and otherwise will not be released without specific authorization, except in certain circumstances which are outlined in the "Notice of Privacy Practices".

I am aware that information concerning my medical treatment and services rendered on my behalf may be released, as necessary, to healthcare providers in case of emergency or to receive payment by public and private health insurance plans.

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that this is a partnership between Dr. El-Asyouty and myself, and as such, I agree to actively participate and acknowledge both my role and responsibility in reference to my healthcare and the right available to me.

ADVANCE DIRECTIVES

Adults 18 and over have the right to give directions about future medical care or to designate another person(s) to make decision if the individual loses decision making capacity.

I have read and understood the financial policy described above,

Patient Name: _____/_____/_____
Print *Sign* *Date*

Parent, Guardian or Conservator: _____/_____
Print *Sign*

Staff representative Initials: _____ Date:_____

Sherif El-Asyouty, MD
334 S Patterson Ave, Ste. 120
Santa Barbara, CA 93111
Phone: (805) 884-4989
Fax: (805) 882-2220

Office and Financial Policy

INSURANCE
As a courtesy to you, we bill your insurance company if we are a participating provider. If we do not participate with your insurance plan, you will be responsible for the cost of the office visit and any procedures performed. **Payment is due at the time of service**. It is the ultimate responsibility of the patient to understand his/her insurance coverage. *Our staff cannot call your insurance company at the time of your visit to obtain information about your benefits*. Insurance policies may change and/or insurance representatives do not always give us correct or consistent information. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered.

PATIENT RESPONSIBILITIES
Patients are responsible for their co-payment and/or deductibles at the time services are rendered. If you are unable to pay your co-pay at the time of service, we may charge you **a $10.00 billing fee**. There is a $25.00 charge for returned checks. We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, or do not provide 24 hours notice, you will be charged a $150.00 "missed appointment fee". If you are a new patient and fail to cancel your initial evaluation appointment, you will be charged $200.00 "missed appointment fee". If you miss two appointments after one another, payment has to be made in advance in order for the patient to be put back on the schedule. **These fees cannot be billed to your insurance carrier and are solely the responsibility of the patient. After two no shows, the $150 fee will increase to $200.**
We require a credit card on file, and will automatically charge for the missed appointment fee.
As mentioned above, it is the patient's responsibility for any co-payment, coinsurance, deductible and non-covered services. This office reserves the right to refer out to collections, any accounts we deem delinquent with one prior notice to the patient. Payment arrangements should be made prior to the account being referred to our collections department.

We thank you for your understanding our financial policies. This has become necessary in order to continue to accept insurance plans without having patients pay the balance up front and then wait themselves for reimbursement from their insurance company.

I have read and understood the financial policy described above,

Patient Signature *Date*

Parent/Guardian Signature (if patient is a minor)

Sherif El-Asyouty, MD
334 S Patterson Ave, Ste. 120
Santa Barbara, CA 93111
Phone: (805) 884-4989
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Dear Valued Patient,

Effective January 1st, 2018, failing to give twenty-four (24) hours notice of cancelation prior to the scheduled appointment will result in a $150.00 charge. For new patients who fail to reschedule or cancel their appointment 24 hours prior will be charged $200.00 for the missed appointment. As mentioned; if you miss two appointments after one another, payment has to be made in advance in order for the patient to be put back on the schedule. We reserve the right to increase the fee from $150.00 to $200.00 for patients with three or more no-shows and/or late cancellations.

As a reminder, co-payments and/or deductibles are expected at the time services are rendered. Effective September 1st, 2008, if you are unable to pay your co-payment we will be charging you a $10.00 billing fee. A bill will also be sent out when there is a balance on an account, which is also subject to a $10.00 fee per bill.

Thank you for your consideration.

Sincerley,
Sherif El-Asyouty, MD.

Please print and sign your name below to insicate that you have been informed about this policy.

_____
Name (please print)

_____
Please Sign

_____
Date

Sherif El-Asyouty, MD

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment income.
- Patients have the right to have their treatment and other patient formation kept private—only by law may records be released without patients permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to share in developing their plan of care.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their case.
- Patients have the right to know about advocacy and community groups and prevention services.
- Patients have the right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibility policy.
- Patients have the responsibility treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need, in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients/Clients have the responsibility not to take actions that could harm them.
- Patients/Clients have the responsibility to report fraud and abuse.
- Patients/Clients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients have the responsibility to understand and help develop plans and goals to improve their health.

I have read and understand my rights and responsibilities,

_____

Name (please print)

_____ _____

Please Sign Date

DR. SHERIF EL-ASYOUTY
PSYCHIATRY

Sherif El-Asyouty, MD
Diplomate of the American Board of Psychiatry and Neurology
334 S Patterson Ave STE 120
Santa Barbara, CA 93111
Phone (805) 884-4989
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Telemedicine Consent Form

1. I authorize Sherif El-Asyouty, M.D. to allow me/the patient to participate in telemedicine (videoconferencing) service with HIPAA Compliant version of Zoom.

2. My/the patient's physician has explained to me the nature and purpose of the videoconferencing technology and has also informed me of the risks, benefits, and complications that may arise during the telemedicine session.

3. I understand that the telemedicine session will not be audio or video recorded at any time.

4. I/the patient understand that my/the patient's insurance will be billed by the healthcare provider for telemedicine services. I/the patient understand that if my insurance does not cover telemedicine services I/the patient will be billed directly by the healthcare provider for the provision of telemedicine services.

5. I/the patient acknowledges that the no-show policy applies to telemedicine sessions.

Patient Signature: _____ Date Signed: _____

DR. SHERIF EL-ASYOUTY
PSYCHIATRY

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Consent Form for Use of Artificial Intelligence (AI) in Clinical Practice

Purpose of AI Use: Our practice uses advanced Artificial Intelligence (AI) systems to assist in various aspects of patient care. These tools help improve the efficiency of your visit, support accurate documentation, and enhance overall care. Specifically, AI will be used in the following ways:

1. **During Patient Interviews:** AI systems may assist the physician in generating clinical notes based on the conversation and information shared during your appointment. This technology helps ensure that your visit is documented accurately and efficiently, allowing the physician to focus more on your care.
2. **Medication Appeals to Insurance Companies:** AI may also be used to help draft medication appeal letters to insurance companies, advocating for necessary treatments or medications. This process can improve the speed and effectiveness of your care plan.

Your Rights:

- **Voluntary Participation:** You have the right to refuse the use of AI in your care. If you prefer not to have AI involved in generating clinical notes or medication appeals, your physician will manually document your information and handle any insurance appeals without AI assistance. This decision will not affect the quality of care you receive.
- **Confidentiality and Privacy:** We prioritize your confidentiality and data security. All information processed by AI systems is handled in compliance with strict privacy regulations and best practices. We are committed to protecting your personal health information (PHI) and will not use AI in a way that compromises your confidentiality.

Why AI is Used:

- AI tools are used to **save time** and **improve efficiency**, allowing you to spend more time discussing your health with your physician rather than on administrative tasks.
- AI helps **reduce the risk of errors** in clinical documentation and improves the accuracy of the information shared with insurance companies to support your care.

Acknowledgement and Consent: By signing this form, you acknowledge that you have been informed about the use of AI systems in your care, understand your rights, and consent to the use of AI as described above. You also acknowledge that your decision to accept or decline the use of AI will not affect the level or quality of care you receive.

If you have any questions or concerns about the use of AI in your care, please feel free to ask your physician or contact our office at any time.

Patient Consent:

I have read and understood the information provided above regarding the use of AI systems during my medical visits. I understand that I have the option to decline the use of AI, and that my decision will be respected without affecting the care I receive.

Patient Name (Print): _____

Patient Signature: _____

Date: _____